6/3/10 POC accepted
B. Cavaney HFS III

PRINTED: 05/17/2010
FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2355SNF	A. BUILDING _____ B. WING _____	05/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of a State licensure complaint investigation conducted in your facility on 5/6/10 and finalized on 5/12/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. The State licensure investigation was conducted concurrently with the Medicare complaint investigation in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. Complaint #NV00025140 was substantiated with deficiency cited. (See tag Z300) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000	RECEIVED MAY 28 2010 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	
Z300 SS=G	NAC 449.74491 Prohibited practices 1. A facility for skilled nursing shall adopt and carry out written policies and procedures that prohibit: a) The mistreatment and neglect of the patients in the facility;	Z300	**Z300 Prohibit Mistreatment/ Neglect/Misappropriation** It is the policy of this facility that policies and procedures are implemented to prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 5/25/10

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Z300	Continued From page 1 b) The verbal, sexual, physical and mental abuse of the patients in the facility; c) Corporal punishment and involuntary seclusion; and d) The misappropriation of the property of the patients in the facility. This Regulation is not met as evidenced by: Based on record review, interview and policy review the facility failed to honor a resident request for transport to an acute care facility for a complaint of lower abdominal pain and constipation that resulted in a diagnosis and treatment of a fecal impaction for 1 of 16 residents. (Resident #1) Findings include: Resident #1 was admitted to the facility on 4/1/10 with diagnoses including congestive heart failure, atrial fibrillation, hypertension, Type II diabetes, and renal failure. The resident verbalized on admission that she had a history of constipation. Record review of the medical record for Resident #1 revealed the following: 1. An order on 4/1/10 for the "House Bowel Program" that included monitor bowel elimination each shift and chart; Milk of Magnesia 30 cc's as needed for constipation; Dulcolax Suppository, one rectally as needed if the Milk of Magnesia is ineffective; and Fleets Enema, one rectally daily as needed if Milk of Magnesia and Dulcolax suppository were ineffective. 2. A Bowel and Bladder Evaluation was completed on 4/1/10 for Resident #1. The inability to get to the toilet independently with a "possible action" of establishing a toileting	Z300	**Residents with Potential Risks** Resident #1 went to the acute hospital where it was determined that she had a bowel impaction. Residents who reside in this facility have the potential to be harmed by the failure to comply with this policy. **Corrective Action** Licensed staff will be in-serviced on: • Abuse policies • Honoring resident rights • Resident assessment • Documentation of Bowel Movements • Care Plans for residents at risk for constipation • Following facility policies and procedures for residents at risk for constipation Evergreen Care Representative forms will be utilized by department managers weekly to identify any concerns that residents may have and to ensure that resident rights are being honored. Executive Director will attend the monthly Resident Council meeting every month for the next 90 days to assist in educating residents on their rights and to review with residents any concerns regarding their rights.	

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Z300	Continued From page 2 program was documented. The record failed to have evidence of any care plan or actions implemented. 3. A Bowel Monitoring flow sheet for Resident #1 for April 2010, revealed that bowel movements or interventions to address constipation were documented as follows: a bowel movement after having milk of magnesia, dulcolax suppository, and a fleets enema on 4/3/10; an illegible mark made in the night shift bowel elimination column and the fleets enema order was discontinued on 4/5/10; and a bowel movement was documented on 4/10/10. 4. A nurse's notes entry in dated 4/4/10 at 7:00 PM, by registered nurse (RN) #1 that read: "...complaining of not being able to have a regular bowel movement, suggested to get medications for constipation from regular doctor..." 5. An entry in Resident #1's medical record in the"Interdisciplinary Progress Notes" dated 4/5/10, by the DON read: "...Resident is concerned with her bowels. It is reported that she suffers from severe constipation, and nursing attempts at relief using routine bowel protocol is minimally successful at best. Colace 100 milligrams twice daily was added." 6. A nurse's notes entry dated 4/5/10 at 6:30 PM, by licensed practical nurse (LPN) #2 that read: "...states she wants to see the doctor right now, she states she is in pain down in the lower quadrants, nurse encouraged her to take her medications, patient absolutely refuses to take the medication, wants to call an ambulance..." At 8:15 PM the note read "Patient has been sitting quietly up at front desk, no apparent distress, nurse within eye/earshot at all times, she phoned	Z300	Customer satisfaction surveys will be completed by Social Services prior to discharge to ensure that any resident concerns have been addressed. **Implemented Measure to ensure Compliance/Monitoring of Compliance** Director of Nursing Services or her designee will complete random audits during the next thirty days to ensure compliance. Findings will be reported to the facility Continuous Quality Improvement Committee. Executive Director will report findings of Resident Council meetings, Evergreen Care Representative rounds and Customer Satisfaction Surveys to the facility's Continuous Quality Improvement Committee.	5/31/10

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Z300	Continued From page 3 911 and asked for an ambulance. Dispatched (sic) called to speak with nurse proper information passed about patient's present condition. Ambulance had already been dispatched." Review of the acute care facility Emergency Department treatment summary for Resident #1 dated 4/6/10, revealed the following: "Chief complaint: Belly pain Started Saturday (4/3/10), gradual onset, lower quadrant Last bowel movement 4/3/10, since then cannot go. GI assessment: Bloating pain, possible constipation. No nausea, just vomiting... Rectal assessment: Positive fecal impaction..." "Diagnostic Studies: KUB shows fecal impaction..." "Emergency room course: Mineral oil enema, she produced some stool with it, but on exam, still had fecal impaction. With the aid of nursing staff, Emergency Room physician manually disimpacted the patient about 5-6 apple size chunks of dark brown stool were pulled out of the rectum." "Medical Decision Making: The patient's presentation symptoms are consistent of fecal impaction, symptoms resolved after post-manual disimpaction" "Impression: 1. Acute lower quadrant abdominal pain 2. Fecal impaction" "Plan:	Z300		

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Z300	Continued From page 4 She is discharged back to the nursing home. Discharge orders have been left on an order sheet. 1. Magnesium citrate 1 bottle once a day for 3 days as needed for constipation 2. Fleet enema twice a day as needed for constipation 3. Continue the Colace twice a day 4. Repeat the basic electrolyte panel on 4/6/10 to document that the potassium is not high enough to require dialysis 5. Otherwise, continue her current medications. Return instructions are given verbally and on discharge sheet." Review of the facility medical record failed to reveal evidence that the above discharge orders had been noted or carried out. The facility medical record had no documentation of when or how the resident had returned to the facility. The minimum data set (MDS) nurse was interviewed on 5/7/10 at 1:20 PM, and reported that the Resident #1 should have had a care plan for bowel elimination and that she did not have an answer as to why the resident had no care plan in the medical record. RN #1 was interviewed on 5/12/10 at 11:00 AM, and reported that constipation had been an ongoing problem for Resident #1, but that she did not think that it was an acute issue for the patient at that time. She reported that she did not recall if she had fully assessed the patient at the time of the complaint, but did recall listening to her bowel tones and that they were hyperactive at that time. She did not call the physician. LPN #2 was interviewed on 5/12/10 at 2:00 PM, and reported that she did recall Resident #1 on	Z300		

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Z300	Continued From page 5 4/6/10 and that she had called 911. She reported that the resident was being very forceful and demanding to go to the hospital. LPN #2 reported that she had assessed the resident but did not recall if she had done "a complete assessment" of the resident. She recalled that the resident had been sitting quietly prior to calling 911 herself from the nurses station. She reported that the resident had no apparent signs or symptoms of distress. She reported that the resident had not been crying, doubled up in pain, or showing any other signs of discomfort other than verbalization of abdominal pain and wanting to go to the hospital. She reported that she felt that the resident "had just been acting out the way a confused person often does, saying get me out of here, I want to leave." When asked if she ever recalled any indication that the resident had been confused or in an altered state, LPN #2 reported "no, she seemed very articulate, and had an extensive vocabulary that led me to believe that she was an intelligent and oriented woman." LPN #1 further reported that she was so convinced that the resident had no acute medical problems, that she "made the resident sign a waiver, as if she were going out on pass" because she felt that the resident "needed to be held accountable for choosing to go to the hospital for no good reason." She further reported that she told the resident that she would have to find her own way back to the facility and that the facility staff would not be responsible for ensuring that she was returned to the facility. When asked if she could recall how the resident was returned to the facility she reported that she could not recall. Review of the facility's Core Systems Manual" revealed a policy#: CSM (B&B) 005, Revision date: 4/8/2002, Management Committee	Z300		

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Z300	Continued From page 6 Approval Date: April 8, 2002, that read: Subject: Fecal Impaction Policy Statement: Resident will not develop impactions Procedure: 1. Residents are assessed at admission and quarterly thereafter for fecal impaction utilizing the Minimum Data Set Assessment. 2. Each resident is placed on a daily bowel monitoring program. 3. For residents at risk for constipation/fecal impaction, implement the following care plan interventions as appropriate (The impaction Risk Assessment may be used as a guide for further assessment): -Initiate hydration program -Increase fiber in diet -Increase exercise and physical activity -Initiate a toileting/retraining program -Administer stool softener per physicians's order 4. The licensed nurse reviews the bowel monitors daily 5. If a resident does not have a bowel movement for 3 days, or has a sequence of 3 small bowel movements in 5 days, administer Milk of Magnesia per physician order on day 3. 6. If Milk of Magnesia offers no results, administer a stimulant laxative suppository (Bisacodyl, etc.) per physician order on day 4. 7. If resident continues to have no results, administer an enema on day 5. Review of the facility's Abuse Prohibition Policy revealed the following: Prohibition EHC-APM 1.01, Effective 2/02, Last revised: 2/07, read: Subject: Abuse, Neglect, Misappropriation of Resident Property Prohibition Policy Statement:	Z300		

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Z300	Continued From page 7 Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility should implement policies and procedures so that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents. Definitions: Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Severity: 3 Scope: 1	Z300		